	T OF HEALTH AND HUI R MEDICARE & MEDIC						TED: 12/28/2011 RM APPROVED B NO. 0938-0391
	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155176			LDING	ONSTRUCTION 00	(X3) DATE COMPL 12/02/2	ETED
NAME OF PROVIDER OR SUPPLIER GLENBROOK REHABILITATION & SKILLED NURSING CENT			STREET ADDRESS, CITY, STATE, ZIP CODE 3811 PARNELL AVE FORT WAYNE, IN46805				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0000	State Licensure S	ovember 28, 29 & 30, , 2011 000092 :: 155176 00266090	FO	0000	The creation and submission this plan of correction does constitute an admission by the provider of any conclusions forth in the statement of deficiencies, or any violation regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of crediallegation and request a desireview in lieu of a post surversiew on or after December 2011.	not his et of e ible sk	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Rick Blain RN Sheryl Roth RN

Census bed type: SNF/NF:

Census payor type:

Stage 2 sample: 35

Total:

Medicare: Medicaid:

Other: Total:

67

67

53 10

67

These state findings are cited in accordance with 410 IAC 16.2.

Quality review completed 12/8/11

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155176	A. BUII	DING	ONSTRUCTION 00	(X3) DATE : COMPL 12/02/2	ETED
		133170	B. WIN			12/02/2	511
	ROVIDER OR SUPPLIER	FION & SKILLED NURSING CENT	FR	3811 P	ADDRESS, CITY, STATE, ZIP CODE ARNELL AVE WAYNE, IN46805		
					, , , , , , , , , , , , , , , , , , ,		
(X4) ID		FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
F0241	Cathy Emswiller The facility must p	RN romote care for residents in					
SS=D	maintains or enharm and respect in full individuality. Based on obserecord review the respect the digital and respect to the digital and respect the digital and respect to the digital and res	n environment that nces each resident's dignity recognition of his or her rvation, interview and ne facility failed to nity of 1 resident in the stage 2 sample	F0	241	F 241: Dignity and Respect of Individuality:It is the practice this provider to promote care all residents in a manner and	of for I in	12/29/2011
	of 35 residents. Finding include				an environment that maintain enhances each resident's dig and respect. What corrective action(s) will be accomplishe those residents found to have been affected by the deficient	gnity e d for e	
	Review of the clinical record for Resident #53 on 11/30/11 at 2:36 p.m., indicated the following: diagnoses included, but were not limited to, epilepsy, depression, congestive heart failure, and anemia.				practice? Social Service Direction interviewed Resident #53 in regards to events. Resident was offered to change tables dining room and refused. However, will you identify other resider having the potential to be affected by the same deficient practice.	#53 in ow its ected e	
	6/10/11, indicat	Resident #53, dated ted a BIMS (Brief ental Status) indicated tut of 15, which	taken? All residents have potential to be affected by deficient practice. Residuality at same table as \$\pi #53\$ were interviewed ar not agitated by visitors of the table during meal time staff in-serviced on 12/0		and what corrective action w taken? All residents have the potential to be affected by all deficient practice. Residents sitting at same table as Residents were interviewed and we not agitated by visitors going the table during meal times. staff in-serviced on 12/02/11 again on 12/13/11 by Social	e eged dent ere by All	
	meal on 10/28/ Resident #53 w	rvation of the lunch 11 at 11:55 a.m., as seated at her he dining room. The			Services Director on followin main pathway in the dining roand to not take shortcuts by resident's table during meal times. Tables were re-arranged.	oom	

000092

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL		
		155176	B. WIN			12/02/2	011
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CEN	ΓER	3811 PA	ADDRESS, CITY, STATE, ZIP CODE ARNELL AVE VAYNE, IN46805		
(X4) ID PREFIX TAG	summary s' (EACH DEFICIEN REGULATORY OR dining room in observed to be sections, with each of the diverse floor to comiddle of the diverse floor the front that through the din through the front immediately newhere it turned toward the 100 dining room we that allowed a shortcut from the 100 Hall and be dining table of the 12:08 p.m., a mas observed to through the din through t	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) the facility was divided into two each section defined by eiling columns in the ining room defining a he front hall of the the dining room. The designated a turn to the e 100 Hall which staff re to use when moving hall of the facility ing room into the 100 #53's dining table was right side of the dining hall. The tables in the ere placed at an angle visual and physical he dining room into the eack right next to the eack right next to the Resident #53. ervation on 11/28/11 at hale teenage visitor to make the shortcut ing room from the 100 ly next to Resident esident #53 became heard to inform the visitor he needed to go	TER		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) on 12/06/11 in the dining roo eliminate the short cut path. What measures will be put in place or what systemic change will you make to ensure that deficient practice does not read All staff in-serviced on 12/02/2 and again on 12/13/11 by So services Director on following main pathway in the dining roand to not take shortcuts by resident's table during meal times. Tables were re-arrang on 12/06/11 in the dining roo eliminate the short cut path. Department Managers and/o Unit Manager is assigned to meals daily to monitor and document that dining room is being used as a pathway. He the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., where the deficient pract	m to to ges the cur? /11 cial goom ged m to r all s not ow e cient hat ill be m for eks, en QI e, ional e.	(X5) COMPLETION DATE
	She also inform	le on the walkway. ned him going next to not a cut-through. At			disciplinary action up to and including termination.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155176	B. WIN			12/02/2	011
			J. 1111		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIER	8			ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	ITER		VAYNE, IN46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTI		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	12:13 p.m., a female visitor and a						
	female child were observed to also						
	cut-through the dining room from the						
	100 Hall next to	o her dining table.					
	Resident #53 v	vas observed to					
	become upset	with them as well. At					
	1	outside vendor to the					
		served to pull a flat bed					
	1	h green duffel bags					
		me area next to her					
	. •	it #53 was observed to					
		and shake her head.					
	· •	two un-identified staff					
		to do the same thing.					
		vas eating her lunch					
	meal during the	_					
	Theat during the	obscivation.					
	Resident #53 v	vas interviewed on					
	11/29/11 at 1:2	24 p.m. During the					
	interview she ii	ndicated people were					
	not to cut throu	igh the dining room					
	next to her tab	le. She also indicated					
	she was bothe	red by people walking					
		closely while she was					
	1	rther indicated she had					
		cility about this and					
		ner people were not to					
	1	y kept doing it anyway.					
		,					
	During an obse	ervation of the lunch					
	_	/11 at 11:32 a.m.,					
		vas seated at the same					
		ne dining table. At					
	I -	N #2 was observed to					
	· ·						
	make the SHOH	cut through the dining					<u> </u>

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION OO	(X3) DATE COMPL			
ANDILAN	OI CORRECTION	155176		LDING	00	12/02/2		
		100170	B. WIN		DDDDGG GUTTY GT TT TT	12/02/2	V 1 1	
NAME OF I	PROVIDER OR SUPPLIER	8	STREET ADDRESS, CITY, STATE, ZIP CODE 3811 PARNELL AVE					
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	TER		VAYNE, IN46805			
(X4) ID		TATEMENT OF DEFICIENCIES	·	ID	·		(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
	room next to R	esident #53's table into						
	the 100 Hall, fo	ollowed by the Director						
		1:39 a.m. At 11:46						
	a.m., a visitor to	o the facility was						
	observed comi	ng from the outside						
	into the dining	room and made the						
	_	h the dining room next						
	to Resident #53	3's table into the 100						
	Hall. At 12:02	p.m., Physical Therapy						
	#3 was observe	ed to make the shortcut						
	through the din	ing room next to						
	Resident #53's	table into the 100 Hall						
	and at the sam	e time an un-identified						
	staff member w	alked from the 100						
	Hall through the	e dining room next to						
	Resident #53's	table to the front hall						
	of the facility.	At 12:08 p.m., an						
	outside Hospic	e nurse to the facility						
	was observed of	coming from the						
	outside into the	e dining room and						
	wander through	n the dining room						
	among many d	ining tables ending up						
	walking next to	Resident #53's table						
	on her way to t	he 100 Hall. She was						
	not observed to	use the designated						
	walkway at all.	At 12:10 p.m., an						
		ousekeeping aide was						
	observed to ma	ake the shortcut from						
	the 100 Hall thr	rough the dining room						
	next to Resider	nt #53's table to the						
	front hall of the	facility. At 12:15 p.m.,						
	the same un-id	entified housekeeping						
	aide was obser	ved coming from the						
	outside into the	e dining room and						
	made the short	cut through the dining						

000092

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155176			LDING	NSTRUCTION 00) DATE SURVEY COMPLETED 2/02/2011				
			B. WIN		DDRESS, CITY, STATE, ZI	IP CODE				
	ROVIDER OR SUPPLIEF			3811 PARNELL AVE						
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CE	ENTER	FORT V	VAYNE, IN46805					
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION			
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO TI DEFICIENCY	HE APPROPRIATE	DATE			
	room next to R	esident #53's table into								
		Resident #53 was								
		g her lunch meal								
	during the obse	ervation.								
	A current facilit	y policy "Resident								
		sidents' Rights &								
		ctives", with a revision								
		y, 2011, indicated								
		t has a right to a								
	_	nceA facility must								
		dents in a manner and								
		ent that maintains or								
		resident's dignity and ecognition of his or her								
	individuality"	_								
	individuality									
	3.1-3(t)									
FORM CMS-2	567(02-99) Previous Versi	ons Obsolete Event ID:	RJDD11	Facility I	D: 000092 If	continuation sheet	Page 6 of 49			

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155176	(X2) MU A. BUII B. WIN	DING	NSTRUCTION 00	(X3) DATE COMPL 12/02/2	ETED
	ROVIDER OR SUPPLIER	TION & SKILLED NURSING CENT		STREET A	DDRESS, CITY, STATE, ZIP CODE IRNELL AVE JAYNE, IN46805		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0272 SS=D	periodically a com standardized repro- each resident's fur A facility must mak assessment of a re RAI specified by the must include at lea	ke a comprehensive esident's needs, using the ne State. The assessment ast the following:					
	Customary routine Cognitive patterns Communication; Vision; Mood and behavio	; or patterns;					
	Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions;						
	regarding the addi performed through protocols; and	al; summary information					
	Based on recording the facility failed accurate document incontinence stop the Data Set (MDS 1 resident Resident Resident Resident failed to accurate status of 1 of 3	d review and interview, d to ensure the	F0	272	F 272: Comprehensive Assessments:It is the practice this facility to conduct initially periodically a comprehensive accurate, standardized reproducible assessment of e resident's functional capacity What corrective action(s) will accomplished for those resid found to have been affected the deficient practice? Resid #90's assessment was modifi	and each be ents by ent	12/29/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJDD11 Facility ID:

lity ID: 000092

If continuation sheet

Page 7 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION	155176	A. BUI	LDING	00	12/02/2	
		155176	B. WIN			12/02/2	011
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE		
GLENBE	OOK REHABILITA	TION & SKILLED NURSING CEN	TER		ARNELL AVE VAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	I		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	status and serv	vices in a Stage 2			to accurately reflect the uring	ary	
	sample of 35.				incontinence on 12/14/11.	,	
					Resident #55 was assessed	_	
	Findings includ	le:			any pain with gums and/or mand no pain was noted. Res		
					#55 does not want a dental	nacm	
	The record for	Resident #90 was			appointment immediately, at		
	reviewed on 1	I/30/11 at 9:30 a.m.			resident's request of wanting	j to	
	Diagnoses incl	uded, but were not			wait 3 to 4 months, so an appointment was made for N	1arch	
	limited to, chro				5, 2012. How will you identif		
	pulmonary dise	ease, anxiety,			other residents having the	. 9	
	1 '	h blood pressure and			potential to be affected by th		
	coronary artery	•			same deficient practice and		
					corrective action will be take All residents have the potent		
	An External Tra	ansfer Report, dated			be affected by alleged deficient		
	8/11/11, indica	ted Resident #90 was			practice. MDS Coordinator		
	incontinent of u	ırine at times.			and/or designee will review		
					resident's recent assessmen		
	The Activities	of Daily Living (ADL)			urinary incontinent accuracy Social Service Dire tor and/o		
	record, dated 0	9/06/11, indicated			designee will review all resid		
	Resident #90 v	vas incontinent of urine			most current dental assessn		
	three (3) times	during the seven day			for any dental needs and foll		
	assessment pe	eriod. The MDS, dated			up accordingly. What measi will be put into place or what		
	09/06/11, indic	ated the resident was			systemic changes will you m		
	always contine	nt of urine.			to ensure that the deficient		
					practice does not recur? ME		
		of Daily Living (ADL)			Coordinator and/or designee review all resident's recent	WIII	
		0/8/11, indicated			assessments for urinary		
		vas incontinent of urine			incontinent accuracy. Resid		
	, ,	imes during the seven			Assessment Specialist will re	eview	
	1 -	nt period. The MDS,			all residents' incontinent assessments for accuracy.	MDS	
		indicated the resident			Coordinator has been educa		
	was always co	ntinent of urine.			on the importance of accura		
					assessments by Resident		
		on Report, dated			Assessment Specialist on 12/13/11. Social Service Dir	octor	
	11/19/11, indic	ated Resident #90 was			12/13/11. Social Service Dif	ector	

000092

STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	00	COMPL	LETED
		155176	A. BUII B. WIN			12/02/2	011
			D. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ARNELL AVE		
CI ENDE	OOK DEHADII ITA	TION & SKILLED NURSING CENT	-ED		NAYNE, IN46805		
		TION & SKILLED NORSING CENT		FORT			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		ATE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)	-	ing			DATE
	incontinent of t	ooth bowel and bladder.			and/or designee will review residents' most current dent		
					assessment for any dental r		
	The Activities of	of Daily Living (ADL)			and follow up accordingly.		
	record, dated 11/5/11, indicated Resident #90 was incontinent of urine three (3) times during the seven day				the corrective action(s) will t		
					monitored to ensure the defi		
					practice will not recur, i.e., w		
	` '	eriod. The MDS, dated			quality assurance program v		
	•	ted the resident was			put into place? Interdisciplin	-	
	always contine				Team will review all assessr and compare to ADL sheets		
	awayo oonunc	THE OF GITTIE.			during care plan review for	,	
	The Activities	of Daily Living (ADL)			accuracy with the continenc	e on	
	The Activities of Daily Living (ADL) record, dated 11/9/11, indicated				weekly basis during care pla		
	,	•			review. MDS Coordinator a		
		vas incontinent of urine			designee to perform Bladde		
	` '	uring the seven day			Program CQI form to monito		
	•	eriod. The MDS, dated			continent accuracy weekly for		
	11/9/11, indica	ted the resident was			weeks, monthly for 3 months then quarterly for 6 months		
	frequently inco	ntinent of urine.			forward findings to monthly		
					committee for review. Thres		
	The Urinary Co	ontinence coding sheet			of CQI is 90% and an addition		
	for the MDS, d	ated May 2010, was			action plan will be created b		
		e MDS nurse on			committee for any findings of	out of	
	·	:11 a.m. The coding			compliance. Social Service		
		cluded, but were not			Director and/or designee to	COI	
	limited to the fo	•			perform the Dental Service (for dental services weekly for		
		nent: if throughout the			weeks, monthly for 3 months		
	· ·	_			then quarterly for 6 months		
	•	k period the resident			forward findings to CQI		
		nent of urine, without			committee monthly for revie		
	* *	of incontinence.			additional action plan will be		
	1	incontinent: if during			developed by the CQI comn		
	the 7-day look-back period the resident was incontinent less than 7 episodes. This includes incontinence				for any findings below thresl of 90%. Resident Assessment		
					Specialist will review a rando		
					sample of incontinent	O.111	
	of any amount	of urine sufficient to			assessments every 2 weeks	for 4	
	dampen under	garments, briefs, or			weeks and then quarterly		
	•	ytime or nighttime.			thereafter with findings forward	arded	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDDIC	00	COMPL	ETED
		155176		LDING		12/02/2	011
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1	ADDRESS, CITY, STATE, ZIP CODE		
CI ENDD	OOK DELIADILITA	TION & CIVILLED MUDDING CEN	ITED		ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	IIER	FORTV	VAYNE, IN46805		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	- Frequently in	continent: if during the			to the monthly CQI committe		
	7-day look-back period, the resident was incontinent of urine during seven or more episodes but had at least one continent				review. Resident Assessme		
					Specialist will review all resid	dents'	
					incontinent assessments for		
					accuracy. Interdisciplinary T will review oral assessments		
		udos incontinense of			during residents' care plan		
		udes incontinence of			review.		
	any amount of urine, daytime and						
	nighttime.						
	During the reco	ord review on 11/30/11					
	at 10:15 a.m.,	there was no care for					
	urinary incontir	nence only one that					
	stated to assis	t with toileting as					
	needed.	3					
	1100000						
	An interview w	as conducted with the					
		11/30/11 AT 10:10					
	_	ne interview, the MDS					
		d she doesn't always					
		g on the ADL records.					
	She indicated	she talks with staff as					
	well as using the	he ADL sheets but that					
	Resident #90's	abilities fluctuated.					
	An interview w	as conducted with CNA					
		I AT 10:17 a.m. During					
		•					
	•	CNA #1 indicated					
		was occasionally					
	incontinent of t	urine.					
	Surveyor: Strass, A	ngela M.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155176	B. WIN	G		12/02/2	011
NAME OF D	ROVIDER OR SUPPLIEF		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	KOVIDEK OK SOTT LIEF				ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	TER	FORT V	VAYNE, IN46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SECONDS - CROSS-REFERENCED TO THE A		ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Observation of resident #55 on 11/28/11 at 2:00 p.m. indicated the resident had broken and decayed teeth on the upper and lower portion of her mouth.						
	0-44/00/44	40.45					
		: 10:15 a.m. review of					
		admission nursing ated 4/5/10 indicated					
	Review of the	d reddened gums.					
		•					
	(minimum data set) dated 9/22/11 there was no assessment marked in						
	the dental sect						
	lile delitai sect	iori.					
	On 12/2/11 at [.]	10:30 a.m. Interview					
		or of Nursing indicated					
		e any information					
		lent #55 being seen by					
		only information was					
		ssment of the resident's					
		licated reddened gums.					
	On 12/2/11 at	10:33 a.m. interview					
		Service Director					
		esident had not been					
		ist and she does not					
	_	mentation of the					
	_	asked on admission if					
	_	anted to be seen by the					
	dentist.	,					
	3.1-31(d)						

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155176		(X2) MU A. BUII B. WIN	LDING G	NSTRUCTION 00	(X3) DATE (COMPL 12/02/2	ETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3811 PARNELL AVE					
GLENBR	OOK REHABILITAT	TION & SKILLED NURSING CENT	ER	FORT W	VAYNE, IN46805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0279 SS=D	The facility must do care plan for each measurable object a resident's medic psychosocial need comprehensive as The care plan must are to be furnished resident's highest mental, and psych required under §48 would otherwise be but are not provide exercise of rights oright to refuse treat Based on obserecord review, initiate a care president (#75) and develop a care cushion for 1 regidents review the stage 2 sant Findings Included 1. Review of the Resident #75 of a.m., indicated diagnoses included.	velop, review and revise the nensive plan of care. evelop a comprehensive resident that includes lives and timetables to meet al, nursing, and mental and its that are identified in the sessment. St describe the services that it to attain or maintain the practicable physical, osocial well-being as 33.25; and any services that it erequired under §483.25 and due to the resident's under §483.10, including the timent under §483.10(b)(4). rvation, interview and the facility failed to lan for behaviors for 1 and also failed to plan for a wheelchair esident (#69) of 35 and for care plans in including the esident (#69) of 35 and for care plans i	F0	279	F279: Develop Comprehensi Care Plans: It is the practice of this facility to use the results the assessment to develop, review, and revise the reside comprehensive plan of care. What corrective action(s) will accomplished for those reside found to have been affected the deficient practice? Nursing staff was educated on 11/25/by Social Service Director and Assistant Director of Nursing verbally about interventions in place regarding Resident #75 behavior. Resident #75 care and C.N.A. assignment shee updated on 11/30/11. Cushing put on resident #69's chair on 12/01/11 and care plan and C.N.A. assignment sheet was	of of of of ont's be ents by ng 11 d on o's plan t was on	12/29/2011	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	LETED
		155176	A. BUII B. WIN	LDING		12/02/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ARNELL AVE		
CI ENDE		TION & SKILLED NURSING CENT	ED		NAYNE, IN46805		
GLEINDR	ROOK REHABILITA	TION & SKILLED NORSING CENT	EK	FORT	WATNE, IN40803		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	ATE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	fibrillation, oste	eoarthritis, dysphagia,			updated. How will you iden	tify	
	diabetes mellit	us, and hemiplegia.			other residents having the		
					potential to be affected by the same deficient practice and		
	A current phys	ician's order for			corrective action will be take		
		dated for the month of			residents have the potential		
		icated Lexapro 10 mg			affected by the alleged defic		
	daily for depres				practice. All residents place		
	daily lot depice	331011.			Behavior Management care		
	A Pobovioral N	ledicine Evaluation &			will be reviewed by compari	-	
					C.N.A. assignment sheet to		
	_	Note for Resident #75,			plans for accuracy by Socia		
		, indicated his insight			Services Director. Director Nursing will review all reside		
	and judgement	were fair from a scale			with potential for skin break		
	of poor, fair, go	ood, or excellent.			and place cushions on whee		
					if needed and update care p		
	A Nursing Prog	gress Note for Resident			and C.N.A. assignment she	ets to	
		25/11 at 9:48 p.m.,			reflect change. What meas		
	•	riter alerted to res			will be put into place or wha		
		Illway touching other			systemic changes will you n	nake	
	,	itely, res educated on 0			to ensure that the deficient practice does not recur? No	ıroina	
		other res, states that			staff to be in-serviced on	usuig	
	, ,	•			Behavior Management police	v bv	
		the issue is a trouble			DNS and/or designee by	, -,	
	•	otified social services,			12/29/11. New intervention:	S,	
	ADON notified	, notified res wife"			which may include 15-minut		
					check, will be initiated by ch	-	
	A Social Service	ce Progress Note for			nurse immediately with any		
	Resident #75,	dated 11/25/11 at 4:25			or worsening behavior that on off hours. Charge nurse		
	p.m. and recor	ded as a late entry on			inform/in-service all applical		
	11/30/11 at 9:2	28 p.m., indicated			nursing staff on all intervent		
	"Writer spoke				to reduce or eliminate any n		
	•	ing report related to			worsening behaviors. Resid		
		emale resident on			will be placed on hot chartin	g for	
	_	ent voiced that aid (sic)			new or worsening behavior.		
		• ,			Nursing staff to be in-service		
		t was trying to make			Behavior Management police	y by	
		. He stated he was			DNS and/or designee by		
	I trying to give re	esident a hug. He	1		12/29/11. Resident skin		1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155176 12/02/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3811 PARNELL AVE GLENBROOK REHABILITATION & SKILLED NURSING CENTER FORT WAYNE, IN46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE voiced he did nothing wrong or that he assessments are performed weekly and residents identified was ashamed of. Writer reminded with potential for skin breakdown him that he is married and that if will have a cushion placed on female resident voiced she did not wheelchair and c are plan and want to be touched or that he hurt C.N.A. assignment sheets will be updated. How the corrective her, he could be charged with assault. action(s) will be monitored to He voiced understanding. Writer ensure the deficient practice will reminded him that he can shake not recur, i.e., what quality hands with other peers but he is not assurance program will be put to hug, rub arm or kiss them. He into place? Social Services Director and/or designee will stated he knew writer was doing her utilize the Behavior Management iob and looking out for him and that CQI form weekly for 4 weeks. he would remember what was asked monthly for 3 months, then but that he still felt he did not do quarterly for 6 months thereafter. anything wrong...." Results will be forwarded to the CQI committee monthly for review. An additional action plan An IDT (Interdisciplinary Team) will be developed by the CQI Progress Note for Resident #75, committee for any findings below dated 11/25/11 at 4:30 p.m. and threshold of 90%. DNS and/or designee will use the Care Plan recorded as a late entry on 11/30/11 Updating CQI form weekly for 4 at 9:32 p.m., indicated the ADON and weeks, then monthly for 3 Social Service Director were present. months, then quarterly for 6 The progress note also indicated months to monitor for "...Upon hearing incident where it was compliance. Results will be forwarded to the CQI committee reported that resident had touched a monthly for review. An additional female resident's breast outside of action plan will be developed by clothes, team determine that resident the CQI committee for any would be placed on a behavior plan. findings below threshold of 90%. During incident, removing resident Non-compliance may result in disciplinary action up to and from situation and speaking with him including termination. were effective strategies. This is new behavior for resident and reportable. Female peer was not affected by interaction at this time...."

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RJDD11

Facility ID:

000092

If continuation sheet

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155176		LDING	NSTRUCTION 00	(X3) DATE COMPL 12/02/2	ETED
NAME OF P	ROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
GLENBR	OOK REHABILITA	FION & SKILLED NURSING CEN	TER		ARNELL AVE VAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	An All Staff Belfor Resident #7 3:15 p.m., indice middle of hall resident's breast resident, remove female resident became agitate you think. Write resident. Resident	navior Tracking Record '5, dated 11/26/11 at eated "Resident in ubbing on [female] st. Approached yed his hand off of t's breast. Resident ed saying it's not what er removed [female] dent following writter		TAG			DATE
		ximately) 2:55 pm to raction that occurred					

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLI		(X2) MU	JLTIPLE CO	NSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUM	IBER:	A. BUIL	DING	00		COMPL	
		155176		B. WING				12/02/2	U11
NAME OF P	ROVIDER OR SUPPLIER				STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
						ARNELL AVE			
GLENBR	OOK REHABILITA	TION & SKILLED N	URSING CENT	ER	FORT V	VAYNE, IN4680	5		
(X4) ID		TATEMENT OF DEFICIE			ID	PROVIDER'S PI	LAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDE			PREFIX	CROSS-REFERENCE	E ACTION SHOULD BE ED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFO			TAG	DEFI	ICIENCY)		DATE
		th resident [Resi							
		resident] voiced							
		entered her room	m,						
	which he has d	one before and							
	grumbled some	ething that she d	id not						
	understand, bu	t [Resident #75]	went						
	on to ask if she	knew what was	going						
	on around the l	building. She sta	ated no						
	and then he vo	iced that people	were						
	trying to get hir	n into trouble an	d then						
	asked if she kn	ew what a							
	[documented s	ex act] was whic	h she						
	-	er. She said sh							
	not scared just	surprised and fe	elt like						
	_	was trying to ge							
	on his side"	, 5 9-							
	Review of the o	current care plan	ıs, with						
		ites of 3/4/11, 3/							
		, 4/26/11, 5/19/1	-						
	-	7/11, in the clinic	-						
	· ·	dent #75 did not							
		e plan addressi							
	behaviors.		3						
	LPN #11 was ir	nterviewed on 1	1/30/11						
	at 3:20 p.m. D	uring the intervie	ew he						
	•	ng staff were no							
		navior charting o							
		also indicated be							
	charting had be								
		on 11/25/11 and	was						
		9/11 due to beha							
		. He further indi	-						
	_	be done on eac							
EODM CMC 2				DD44	Earth 1	D: 000000	If continued :	naat D	40 -f 40
гокм СМS-2	567(02-99) Previous Version	ons Obsolete	Event ID: RJ	DD11	Facility I	D: 000092	If continuation sl	ieet Pa	ge 16 of 49

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155176	B. WIN	G		12/02/2	011
NAME OF P	ROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP CODE		
CL ENDD		TION & SKILLED NURSING CEN	red		ARNELL AVE		
	OOK REHABILITA	TION & SKILLED NORSING CEN	IEK		WAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	-	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
1710	REGUERTORTOR	LEGE IDENTIFY THING IN ORDER THON	+	mo	<u> </u>		DATE
	The Director of	Nursing was					
		12/1/11 at 3:15 p.m.					
		rview she indicated a					
	_	plan was the same					
	·						
	thing as a beha	avior plan.					
	The Assistant I	Director of Nursing was					
		12/1/11 at 4:04 p.m.					
		rview she indicated					
	_	vas placed on the					
		narting" on 11/25/11					
	•	lent with another					
		t. She also indicated					
		neant nursing staff					
	_	n Resident #75 each					
	_	-					
		•					
	•						
		•					
	-	_					
	Tiot charting c	ione.					
	Δ current unda	ted facility "ASC					
		-					
		•					
	• •	<u> </u>					
		3					
		•					
	Nursing further had behavior behavior plans resident's behavior staff were to us occurred. She #75 did not have developed on "hot charting" of A current unda Behavior Mana Procedure", pro Administrator of a.m., indicated be initiated for	ted facility "ASC agement Policy & ovided by the on 12/2/11 at 10:15 "Care plan should any behavioral issue has the potential to					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/28/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED
		155176	B. WIN			12/02/2	U11
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CENT	ER	3811 PA	DDRESS, CITY, STATE, ZIP CODE ARNELL AVE VAYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	been identified monitoring and interventions id plan should the monitoring form interventions id Behavior Monit the CNA (Certit assignment shocommunication interventionsl behaviors are r IDTThe IDT r discussion with behavior event interventions, p interventions if assessment of of the distressed A current facilit Sheet for Residue the Director of 4:15 p.m., did r #75 had any be	lentified on the care en be transferred to the hThe behaviors and lentified on the coring are also listed on fied Nursing Assistant) eet to assist in of individualized New or worsening eviewed by the eview should be a hathe team as to the hand evaluation of bresentation of new applicable and an any underlying causes ed behavior" y Resident Care/Need dent #75, provided by Nursing on 12/1/11 at not indicate Resident ehaviors which were to bre any interventions of followed if a					

000092

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155176	B. WIN	G		12/02/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
a					ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CENT	IER	FORT	WAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAU	REGULATORT OR	LSC IDENTIFTING INFORMATION)	+	TAU			DATE
	he was seated dining room take not observed to reduction cushing. On 11/30/11 at #69 was observed activity room in resident was no pressure reduction.	resident # 69 indicated in his wheelchair at the ole. The resident was a have a pressure ion. 2:00 p.m. Resident wed seated in the his wheelchair. The ot observed to have a					
		nis wheelchair in the					
		he resident was not					
	observed to ha						
	reduction cush	•					
		-					
	the Annual MC assessment) of indicated resid dependent on activities of da	10:30 a.m. review of OS (minimum data set lated 10/5/11 dent #69 was totally staff for all of his hily living. Review of 5 on 12/1/11 at 10:35					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155176	B. WIN			12/02/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				3811 PA	ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	NTER	FORT V	VAYNE, IN46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ent #69 indicated he					
		skin breakdown.					
		care plan did not					
		esident was to have a					
	pressure redu 	ction cushion.					
	On 12/1/11 of /	10:45 a.m. review of					
		licy "Care Plan					
	-	aintenance" dated					
		rised on 8/2011,					
	indicated the f	· ·					
	indicated the i	ollowing.					
	Policy: It is t	he policy of this					
	1	ch resident will have					
	a comprehens						
	developed and	-					
	· -	re assessment. The					
	-	include measurable					
	goals and resi						
	•	based on resident					
	·	eferences to promote highest level of					
		cluding medical,					
		al and psychosocial					
	needs.	ai and psychosociai					
	necus.						
	Procedure: 0	Care plan problems,					
		rventions will be					
	•	d on changes in					
	l -	ssment/condition,					
		rences or family					
	input.	ionoes or iaining					
	mput.						
	3.1-35(a)						

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155176	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE (COMPL 12/02/2	ETED
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GLENBR	OOK REHABILITAT	TION & SKILLED NURSING CENT	ER		RNELL AVE /AYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
F0280 SS=D	incompetent or oth incapacitated under participate in plant changes in care at the A comprehensive developed within 7 of the comprehensive at the comprehensive at the resident's number of the resident's family the resident's family the resident's family representative; and revised by a team each assessment. Based on record the facility failed care plan for 1 albumin (measure a responsibility failed care plan for 1 albumin (measure a responsibility failed care plan for 1 albumin (measure a responsivited to care president (#69) of criteria for care 2 sample of 35. Findings included.	care plan must be 'd days after the completion sive assessment; prepared eary team, that includes the in, a registered nurse with the resident, and other in disciplines as determined eeds, and, to the extent inticipation of the resident, thy or the resident's legal ind periodically reviewed and of qualified persons after and review and interview, that the dietary interesident with a low the resident with a low the resident with a low the resident with a low the sident with a low the of nutritional int #40) and failed to insible party was the planning in the stage	F0	280	F 280: Right To Participate Planning Care:It is the practic this facility to recognize that residents have the right, unle adjudged incompetent or otherwise found to be incapacitated under the laws the State, to participate in planning care and treatment changes made in the care or treatment. It is also the pract of this facility to update and of develop a care plan within 7 after the completion of a comprehensive assessment. What corrective action(s) will accomplished for those resid found to have been affected	of or tice or days be ents	12/29/2011

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155176	B. WIN			12/02/2	011
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	TER		NAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		uded, but were not			the deficient practice? Resi	dent	
		•			#40 care plan updated on	done	
		stage congestive heart			12/15/11. Resident #69's		
		ge renal disease,			responsible party was notifie	ed of	
	dementia, chro	nic obstructive			the right to attend care		
	pulmonary dise	ease, and diabetes			conferences quarterly on		
	mellitus.				12/16/11. How will you iden	tify	
					other residents having the		
	The "Resident	will be served			potential to be affected by the		
		;," care plan, dated			same deficient practice and corrective action will be take		
	I -	ted to serve a regular			residents have the potential		
		•			affected by the alleged defic		
		od consumption's,			practice. All residents and/o		
		nonitor weights, and			responsible parties will be in		
		440 preferred to eat her			to quarterly care meetings.		
	meals in her ro	om. There were no			Dietary Manager and/or		
	references to t	he residents low			Registered Dietitian will aud		
	albumin levels	nor to the interventions			dietary care plans for any up		
	in place for the	m.			needed. What measures will		
					put into place or what system changes will you make to er		
	The following la	aboratory reports were			that the deficient practice do		
	noted in the cli				not recur? Registered Dieti		
		albumin level 13.2			educated the Dietary Manag		
					policy regarding revising cal		
		bumin level 2.3			plans on 12/15/11. Dietary		
	(3.4-5.0)				Manager will review all care	-	
		albumin level 13.3			and update nutritional care	plans	
	(18.0-35.7)				when completing the MDS		
	06/16/11 pre a	albumin level 3.8			assessment. DNS and/or designee will update Regist	arad	
	(18.0-35.7), al	bumin 2.0 (3.4-5.0)			Dietitian alert sheets for res		
					of nutritional concern, woun		
	The "Resident	Progress Notes, "dated			weight changes, and abnorr		
		Dietary Manager,			labs relating to nutritional st		
		esident remains on a			on a weekly basis. All resid		
					and/or responsible parties a		
		esident receives high			invited quarterly (or more of		
	potency vits (vi	-			needed) to participate in car		
		beneprotein one scoop			plans. Invite will be docume		
	once a day"				in clinical record. Social Se	rvices	

000092

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155176	A. BUII B. WIN			12/02/2	011
			b. why		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CENT	ER		VAYNE, IN46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The current me Resident #40, 10 Dietary Managa.m. The tray 10 #40 as being of special dietary interventions. The most receive Medications" list indicated Residual beneprotein posupplement) or 4/5/11. A telephone into with the Regist 12/2/11 at 1:47 interview, the Finot been notified levels. She indicated she in the facility once a week and sees alert sheet. The weight loss, we indicated she in #40 since she is back in July. The Certified Dietard was interviewed p.m., along with interview, the Certified Dietard interview interview, the Certified Dietard interview interv	eal tray card for was provided by the er on 12/01/11 at 11:06 card listed Resident n a regular diet with no supplemental ont "Routine st, dated 12/1/11, dent #40 was receiving			Director educated by Execution Director on the policy of invitaresident and/or responsible probable and care conferences on 12/21/11. How the corrective action(s) will be monitored to ensure the deficient practice not recur, i.e., what quality assurance program will be printo place? Social Services Director and/or designee will the Care Plan Review CQI are form weekly for 4 weeks, mo for 3 months, then quarterly from months thereafter. Results were forwarded to CQI committee monthly for review. An additication plan will be developed the CQI committee for any findings below threshold of 9 Registered Dietitian to review random sample of dietary caplans monthly and forward findings to the CQI committee monthly for review.	ing party will use udit nthly for 6 vill be ional by 0%. v a re	

If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155176	B. WIN	G		12/02/20)11
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
01 51155		TION A OLW LED NU POING OF	ITED		ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	NIER	FORTV	VAYNE, IN46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	l -	he had tried other					
		uch as peanut butter					
	and toast						
	2 On 11/20/1	1 at 2:15 a m. Intensious					
		1 at 2:15 p.m. Interview					
		69's responsible party					
		nad only been to one					
		ting in the last year.					
	•	she indicated she					
		nly had meetings on a					
	yearly basis.						
		2:30 p.m. interview with					
		vice Director indicated					
		amily/responsible party					
	is notified by m	nail and a copy of the					
	notification is k	ept in the clinical					
	record.						
	On 12/1/11 at 2	2:45 p.m. the Social					
	Service Directo	or presented copies of					
	the care plan n	otification for resident					
		e dated 6/7/10 and					
	10/12/11.						
	On 12/1/11 at :	3:00 p.m. review of					
		clinical record indicated					
		ses including but not					
	limited to down	•					
	minica to down						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155176 NAME OF PROVIDER OR SUPPLIER GLENBROOK REHABILITATION & SKILLED NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (X4) PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X6) PROVIDERS PLAN OF CORRECTION (X7) PROVIDERS PLAN OF CORRECTION (X8) PROVIDERS PLAN OF CORRECTION (X9) PROVIDERS	AND PLAN OF
NAME OF PROVIDER OR SUPPLIER GLENBROOK REHABILITATION & SKILLED NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3811 PARNELL AVE FORT WAYNE, IN46805	
NAME OF PROVIDER OR SUPPLIER GLENBROOK REHABILITATION & SKILLED NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDENCE NAMES CORRECTION (X	
	(X4) ID
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	PREFIX
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DAT	TAG
Alzheimer's disease and seizure disorder. Further review indicated the resident did have a responsible party listed on the "information face sheet" in his clinical record. 3.1-35(c)(2)(C) 3.1-35(d)(2)(B) The services provided or arranged by the facility must be provided by qualified persons in accordance with each residents written plan of care. Based on record review and interview, the facility failed to administer beneprotein as ordered for 1 resident (Resident #40) and failed to follow up on a nephrology consult for 1 of 3 residents (resident #12) who met the criteria for urinary catheter in the stage 2 sample of 35. Findings include: Findings include: 1. The record for Resident #40 was reviewed on 11/30/11 at 10:30 a.m. Diagnoses included, but were not limited to, end stage congestive heart failure, end stage renal disease, dementia, chronic obstructive pulmonary disease, and diabetes Alzheimer's disorder the resident the resident by the deficient practice? Resident with receiving Beneprotein. Resident #12 refuses Nephrology Consultation. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents who receive nutritional supplements have the potential to be affected by the game deficient practice and what corrective action will be taken? Residents who receive nutritional supplements have the potential to be affected by the game deficient practice and what corrective action will be taken? Residents who receive nutritional supplements have the potential to be affected by the game deficient practice and what corrective action will be taken? Residents who receive nutritional supplements have the potential to be affected by all the provided by qualified persons in accordance with each residents who receive nutritional supplements have the potential to be affected by the action of the provided by qualified persons in accordance with each residents who receive nutritional supplements have the potential to be affe	0282 S=D 1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155176	B. WIN	G		12/02/2011	
NAME OF I	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
NAME OF I	ROVIDER OR SUPPLIER			3811 PA	ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	TER	FORT V	VAYNE, IN46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	mellitus.				practice. Director of Nursing		
					and/or designee will complet	e a	
	A telephone or	der dated 2/22/11,			chart audit for all residents receiving nutritional supplem	ont	
	· ·	minister beneprotein			to ensure all Physician order		
		laily for 30 days. The			being followed. Residents w		
	•	Medication sheet			have been admitted or readr		
		eneprotein was			with catheters have the pote	ntial	
		om 3/1/11 through			to be affected by alleged def		
		_			practice. Director or Nursing		
	3/20/11 as ord	cicu.			and/or designee, to ensure t	 	
					recommendations are follow will review all residents' Phys	· .	
	•	linary team note, dated			progress notes. What measu		
	2/18/11, indicated Resident #40 was				will be put into place or what		
		ed from hospice and			systemic changes will you m	 	
	that beneprote	in was to be			to ensure that the deficient		
	administered to	wice daily for 30 days.			practice does not recur? DN	S	
					and/or designee reviews all		
	RN #11 was in	terviewed on 12/2/11 at			Physicians' orders in mornin		
	9:30 a.m. Duri	ng the interview, RN			meeting 5 days a week to er orders are being followed. 2		
	#11 indicated t	-			nurses will review the month	 	
		Record (MAR) needs			re-writes for accuracy. DNS		
		every time a medication			and/or designee will review		
		is given. If something		on			
		•			return from outside physiciar		
	_	en you must circle the			visits and all recommendatio	ns	
		e on the back of the			will be addressed. How the		
	MAR the reaso	on it wasn't given.			corrective action(s) will be monitored to ensure the defi	cient	
					practice will not recur, i.e., w	 	
		2's record was			quality assurance program w		
	reviewed on 17	1/28/11 at 4:35 p.m.			put into place? DNS and/or		
	The record ind	icated Resident #12's			designee will use a		
	diagnoses inclu	uded, but were not			Rewrite/Physician Visits CQ		
	_	ry of bladder cancer,			to monitor weekly for 4 week		
		on, and multiple			then monthly for 3 months, the		
	sclerosis.	,			quarterly for 6 months. Find will be forwarded to the CQI	iiiys	
	55.5.55.5				committee monthly for review	v. An	
	Δ Physician's E	Progress Note, dated			additional action plan will be		
					· · · · · · · · · · · · · · · · · · ·		
FORM CMS-2	2567(02-99) Previous Versi	ons Obsolete Event ID: R	JDD11	Facility l	ID: 000092 If continuation s	heet Page 26 of 49	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/28/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155176		LDING	NSTRUCTION 00	(X3) DATE COMPL 12/02/2	ETED
	ROVIDER OR SUPPLIER	TION & SKILLED NURSING CENT	ER	3811 PA	DDRESS, CITY, STATE, ZIP CODE ARNELL AVE VAYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	for a nephrolog to possible nep During review of there was no dindicate the red been addresse. An interview was Director of Nurs 11/30/11 at 2:4 interview, the E #12 was follow hospital and that there was not row was unable to see the clinical recommendation.	as conducted with the sing (DON) on 0 p.m. During the DON indicated Resident ed by a local veterans at was probably why much in the chart. She show documentation in			developed by the CQI comm for any findings below the threshold of 90%.	ittee	

000092

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155176	A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/02/2	ETED
		155176	B. WIN	G		12/02/2	011
	ROVIDER OR SUPPLIER	FION & SKILLED NURSING CENT	ER	3811 PA	ADDRESS, CITY, STATE, ZIP CODE ARNELL AVE VAYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F0314 SS=D	a resident, the factoresident who enterpressure sores do sores unless the indemonstrates that a resident having precessary treatments healing, prevent in sores from developments from developments and interview the ensure a wheelimplemented for stage 2 samples for skin break of follow their policy regarding implessure reduce. Finding Includes On 11/30/11 at observation of the was seated dining room tabout not observed to reduction cushing the stage of the was observed to reduction cushing the stage of the was seated dining room tabout observed to reduction cushing the stage of the was observed to reduction cushing the was observed t	rvation, record review he facility failed to chair cushion was or 1 resident (#69) in a set of 35 who was at risk down, and failed to cy and procedure ementation of a ing cushion. 12:00 p.m. resident # 69 indicated in his wheelchair at the ble. The resident was on have a pressure on. 2:00 p.m. Resident was on have a wheelchair. The bit observed to have a	F0	314	F 314: Treatment/Services to Prevent/Heal Pressure Sores the practice of this facility to ensure that a resident who ethe facility without pressure sounless the individual's clinical condition demonstrates that were unavoidable. What corrective action(s) will be accomplished for those reside found to have been affected the deficient practice? Cushing put on Resident #69's chair of 12/01/11 and care plan and C.N.A. assignment sheet was updated. How will you identife other residents having the potential to be affected by the same deficient practice and we corrective action will be taken Residents with potential for sobreakdown have the potential be affected by the alleged deficient practice. Review all residents with potential for sobreakdown and place cushio on wheelchair if needed and update care plans and C.N.A assignment sheets to reflect change. What measures will put into place or what system	s:It is nters sores ores ores il they ents by ion on s fy e what n? ekin al to I kin ns	12/29/2011

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155176	B. WIN			12/02/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIEF	ł.		3811 PA	ARNELL AVE		
	OOK REHABILITA	TION & SKILLED NURSING CENT	ER		VAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	,		DATE
		his wheelchair in the			changes will you make to en- that the deficient practice do		
	dining room. The resident was not				not recur? Resident skin	55	
	observed to have a pressure				assessments are performed		
	reduction cushion.				weekly and residents identific	ed	
					with potential for skin breakd		
	On 12/1/11 at 9:00 a.m. Interview				will have a cushion placed or		
	with the DON indicated she thought the resident had a cushion for his wheelchair. On 12/1/11 at 10:30 a.m. review of				wheelchair and care plans an C.N.A. assignment sheets wi		
					updated. Nurses to perform	iii bC	
					rounds to ensure that cushio	ns	
					are in place per care plan an		
					C.N.A. assignment sheet. Ho		
	the Annual MDS (minimum data set				the corrective action(s) will b monitored to ensure the defice		
	assessment) dated 10/5/11				practice will not recur, i.e., w		
	indicated resident #69 was totally				quality assurance program w		
		staff for all of his			put into place? DNS and/or		
	-	aily living. Review of			designee will use the Care P		
		for resident #69,			Updating CQI form weekly fo		
	-				weeks, monthly for 3 months then quarterly for 6 months to		
		, indicated he was at			monitor compliance. Results		
		reakdown, but there			be forwarded to the CQI		
		ention for a pressure			committee monthly for reviev	v. An	
	reduction cus	nion.			additional action plan will be		
					developed by the CQI comm for any findings below the	ıttee	
		11:00 a.m. review of			threshold of 90%. DNS and/	or	
	the clinical red				designee will use the Skin	- '	
	_	for resident #69 as			Management CQI form week		
	follows:				4 weeks, monthly for 3 month	ns,	
					then quarterly for 6 months. Results will be forwarded to the	ho	
	10/25/11 at 6:4	5 a.m. "area noted to			CQI committee monthly for	ıı i C	
	lower right buttocks. Area pink in				review. An additional action	plan	
	color. No drainage noted. No odor				will be developed by the CQI		
	noted. MD and nursing notified.				committee for any findings be	elow	
	New order for peleverus clear twice				the threshold of 90%.		
	daily"	•					
	1		1		l e e e e e e e e e e e e e e e e e e e		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155176 NAME OF PROVIDER OR SUPPLIER GLENBROOK REHABILITATION & SKILLED NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES O A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3811 PARNELL AVE FORT WAYNE, IN46805 (X5)	MULTIPLE CONSTRUCTION (X3) DATE SURVEY	ULTIPLE CO	(X2) N	X1) PROVIDER/SUPPLIER/CLIA	NT OF DEFICIENCIES	STATEMEN	
NAME OF PROVIDER OR SUPPLIER GLENBROOK REHABILITATION & SKILLED NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3811 PARNELL AVE FORT WAYNE, IN46805 (X5)	GUILDING COMPLETED	LDING	A. BU	IDENTIFICATION NUMBER:	OF CORRECTION	AND PLAN	
NAME OF PROVIDER OR SUPPLIER GLENBROOK REHABILITATION & SKILLED NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 3811 PARNELL AVE FORT WAYNE, IN46805 (X5)	12/02/2011			155176			
GLENBROOK REHABILITATION & SKILLED NURSING CENTER Summary Statement of Deficiencies ID PROVIDER'S PLAN OF CORRECTION (X5)	STREET ADDRESS, CITY, STATE, ZIP CODE	STREET A	•		DDOVIDED OD SLIDDI IED	NAME OF B	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)					FROVIDER OR SUFFLIER	NAME OF F	
PROVIDER'S PLAN OF CORRECTION	FORT WAYNE, IN46805	FORT V	ΓER	GLENBROOK REHABILITATION & SKILLED NURSING CENT			
	PROVIDER'S PLAN OF CORRECTION						
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	CROSS-REFERENCED TO THE APPROPRIATE			`			
The RECOLUTION OF ESCHEDISTI THOUSE OF THE STATE OF THE S	IAG DEFICIENCE) DAT	TAG	+	·		TAG	
On 12/1/11 at 11:45 a.m. review of							
the facility policy for "Skin				_	1		
Management" dated 3/10 indicated				dated 3/10 indicated	1		
the following:					the following:		
West also seems to the					\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		
Weekly skin assessments will be					_		
completed on all resident as				all resident as			
follows:							
Weekly skin assessments will be				esosements will be			
completed on all residents with or							
documented on the weekly skin				0 1	without alterations in skin integrity and		
assessment form and/or nursing				-			
notes.				in and/or nursing			
notes.					notes.		
All alterations in skin integrity will				s in skin integrity will	ΔII alterations		
be documented in one of two skin							
evaluation reports depending on							
what type of wound - either					-		
pressure wound (white) or other							
wound (lavender)				` '	•		
Would (lavelide)				AG1)	would (lavelle		
Pressure reduction devices are to				uction devices are to	Pressure redu		
be put in place immediately.							
				· · · · · · · · · · · · · · · · · · ·			
The care plan will be				will be	The care plan		
initiated/revised addressing any					· •		
new areas.				5 ,			
On 12/1/11 at 11:45 a.m. review of				11:45 a.m. review of	On 12/1/11 at 1		
the plan of care for skin for							
resident #69, dated 11/19/10,					· •		
indicated there was no addition of							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155176		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/02/2011	
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CENT	3811 P.	ADDRESS, CITY, STATE, ZIP CODE ARNELL AVE WAYNE, IN46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	-	eving device being or his wheelchair.			
	3.1-40(a)(1) 3.1-40(a)(2)				
F0325 SS=D	assessment, the faresident - (1) Maintains accenutritional status, sprotein levels, unlecondition demonstrations and possible; and	ent's comprehensive acility must ensure that a septable parameters of such as body weight and less the resident's clinical trates that this is not erapeutic diet when there is em.			
	the facility failed approaches to parameters of report (protein levels) resident (#40)in 35. Findings include The record for reviewed on 11 Diagnoses included in the conditional conditions and conditions approaches the condit	achieve acceptable nutritional status were achieved for 1 n the stage 2 sample of	F0325	F 325: Maintain Nutritional S Unless Unavoidable:It is the practice of this facility to ma acceptable parameters of nutritional status and to prea a therapeutic diet when their nutritional problem. What corrective action(s) will be accomplished for those resifound to have been affected the deficient practice? Registical Dietitian reviewed Resident on 12/15/11. Lab levels we drawn on 12/08/11. Reside currently on Beneprotein and plan has been updated. Labe ordered per Physician or How will you identify other	dents d by stered #40 re ent is d care bs will

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S COMPLE	
		155176		LDING		12/02/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t .			ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	TER		VAYNE, IN46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	dementia, chro	nic obstructive			residents having the potentia	l to	
	pulmonary disease, and diabetes				be affected by the same defi	cient	
	mellitus.	aco, and diasotos			practice and what corrective		
	Tricintas.				action will be taken? Reside	nt	
	Laboratory report, dated 09/23/10,				who has pressure sores,		
					significant weight changes, a enteral feedings, or have	iie OII	
		umin level of 13.2			abnormal labs affecting nutri	tional	
		nd an albumin level of			needs has the potential to be		
	2.3 (3.4-5.0)				affected by the alleged defici		
					practice. Dietary Manager a		
	Laboratory report, dated 02/10/11, listed a pre albumin level 13.3 (18.0-35.7).				Registered Dietitian will audi		
					dietary care plans on resider	its	
					who have pressure sores, significant weight changes, h	121/0	
					enteral feedings, or have	lave	
	The laboratory result for pre albumin,				abnormal labs affecting nutri	tional	
	1	indicated the level was			needs for any updates needs		
	-	.0-35.7) for Resident			What measures will be put in		
	#40.	.5 55 , 15. 1 155.155			place or what systemic chan	-	
	" 10.				will you make to ensure that		
	The Interdiscin	linary Team (IDT)			deficient practice does not re		
	· ·	s, dated 2/11/11,			Dietary Manager educated b Registered Dietitian on progr		
	_				note documentation and diet		
		dent #40 had a pre			care plans on 12/15/11. DNS	-	
		of 13.2 on 9/22/10 and			and/or designee will update		
	1	waiting for the pre			Registered Dietitian alert she	ets	
		rawn on 2/10/11. Will			for residents of nutritional		
	continue with c	urrent plan.			concerns, wounds, weight		
					changes, and abnormal labs relating to nutritional status of	,	
	The Interdiscip	linary Team (IDT)			weekly basis so Registered	""	
	Progress Notes	s,dated 2/18/11,			Dietitian can ensure appropr	iate	
	indicated Resid	dent #40 was			follow up has occurred.		
	discharged from	n hospice and that			Registered Dietitian to review		
	1	as to be started twice			random sample of dietary ca	re	
	daily for 30 days.				plans monthly and forward		
					findings to the CQI committe monthly for review. How the		
	The Routine M	edications sheet for			corrective action(s) will be		
					monitored to ensure the defic	cient	
	rebluary 2011	, indicated Resident			The second the delivery		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155176	B. WIN			12/02/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
OLENDO		FION & OKULED NUDOINO OFN	TED		ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	IEK	FORTV	VAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	practice will not recur, i.e., w	hat	DATE
	#40 received beneprotein twice daily from 2/18/11 thru 2/28/11.				quality assurance program w		
					put into place? Registered		
					Dietitian to review a random		
		edications sheet for			sample of dietary care plans		
		dicated Resident #40			monthly and forward findings	to	
		beneprotein during the			CQI committee monthly for review. DNS and/or designe	e will	
	month as ordered. The order had been yellowed out as if it was discontinued. The Routine Medications sheet for April 2011, indicated Resident #40				utilize the Supplement CQI a		
					the Care Plan CQI weekly fo	r 4	
					weeks, monthly for 3 months	,	
					then quarterly for 6 months. Findings will be forwarded to	the	
					CQI committee monthly for	uic	
					review. An action plan will be	е	
	received beneprotein once daily from 4/511 thru the end of April. There				developed by committee if		
					threshold of 90% is not met.		
		entation of beneprotein					
		ered from 4/1/11 thru					
	4/4/11.						
	 IDT 4/4/44 \will	request MD eval d/t					
		request MD eval d/t ımin/pre albumin et					
	request supple	•					
	l neuebioreiu bo	wder started 4/5/11.					
	The Routine M	edications sheet for					
		cated Resident #40					
	1	coop of beneprotein					
		1 thru 5/14/11 before					
	1	to the hospital. Upon					
	return, the shee						
	· '	ed beneprotein, one					
		m 5/27/11 thru 5/31/11.					
	accop daily iron	11 0/2// 11 tillu 0/01/11.					
	The Dietary Pro	ogress Note, dated					
		ed to discontinue					
	•	d suggested double					
	L periopiotein an	a saggested double					

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155176	B. WIN	G		12/02/2	011
NAME OF E	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	IER	FORTV	VAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		+	TAG	DEFICIENCY)		DATE
	00	ast to increase protein.					
	The note further indicated Resident #40 had been consuming 75% of breakfast.						
	The Routine M	edications sheet for					
	June 2011, indicated Resident #40 received beneprotein one scoop daily for the month of June.						
	Laboratory report, dated 06/16/11,						
	listed a pre albumin level of 3.8 (18.0-35.7), and albumin level of 2.0						
	(3.4-5.0).						
	,						
	The Dietary Pr	ogress Notes, dated					
	6/21/11, indica	ted Resident #40 was					
		protein, one scoop in 8					
		er and that the resident					
		breakfast 30%, lunch					
	35%, dinner 55	5%.					
	The 115 11 1	Donama a N. C. B. C. C.					
		Progress Notes, "dated					
	,	Dietary Manager,					
		esident remains on a					
	1 -	esident receives high					
	potency vits (vi	•					
		beneprotein one scoop					
	once a day"						
	The Poutine M	edications sheet, dated					
		ndicated Resident #40					
		protein one scoop daily					
	for the month of						
		n nagasi.					

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155176	B. WIN			12/02/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹		3811 P	ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	TER		VAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		edications sheet dated					
	September 2011, indicated Resident #40 received beneprotein one scoop daily for the month of September.						
	The current ca	The current care plan, dated 9/22/11					
	for "Resident will be served prescribed diet," was provided by the Director of Nursing on 12/1/11 at 10:45 a.m. The care indicated to monitor food consumption's, monitor labs, monitor weights, and serve						
	regular diet.						
	regulai diet.						
	The Poutine M	edications sheet dated					
		indicated Resident #40					
		orotein one scoop daily					
	for the month of	of October.					
	The "Resident	Progress Notes," dated					
		e Dietary Manager,					
	•	esident remains on a					
		esident receives high					
	•	•					
	potency vits (vi	•					
		beneprotein one scoop					
	once a day"						
	T la a (to					
		eal tray card for					
		was provided by the					
	•	er on 12/01/11 at 11:06					
	a.m. The tray card listed Resident						
	#40 as being o	n a regular diet with no					
	special dietary	_					
	interventions.						

i '		X1) PROVIDER/SUPPI							
AND PLAN	OF CORRECTION	IDENTIFICATION NU	MBER:	A. BUII	DING	00		COMPL	
		155176		B. WIN	G			12/02/2	011
NAME OF I	PROVIDER OR SUPPLIE	ρ.		-	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
				3811 PARNELL AVE					
GLENBR	OOK REHABILITA	TION & SKILLED I	NURSING CEI	NTER	FORT W	VAYNE, IN4680	5		
(X4) ID	SUMMARY S	STATEMENT OF DEFICE	IENCIES		ID		PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PERCED!			PREFIX	CROSS-REFERENCE	/E ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION
TAG		R LSC IDENTIFYING INI	FORMATION)		TAG	DEF	TICIENCY)		DATE
	The most rece								
		st, dated 12/1/1	•						
	indicated Resident #40 was receiving beneprotein powder (protein supplement) once daily effective								
	4/5/11.								
	0 40/0/44	44.00 - "							
		11:00 a.m., the	امامات						
	Certified Dietary Manager provided a								
	copy of the current policy "Referrals to								
	Dietitian," dated 5/06. The policy								
	indicated "facility staff will refer nutritional problems to the Registered								
	•								
		ed/Certified Diet							
		opriate formas							
	•	e, staff will use th							
		vided to notify th	ne						
	Registered Die	•							
		tine referrals wil							
		the dietitian's vi							
		es Manager and							
		II provide the Di							
		e residents no le							
	,	have pressure ι	ulcers,						
	significant weig								
		ntinuation of ent	teral						
	feedings"								
			and the						
	· ·	terview was cor							
	with the Registered Dietitian (RD) on								
	12/2/11 at 1:47 p.m. During the								
	interview, the RD indicated she had								
	not been notified of the low albumin								
		dicated she is in							
	facility once a	week or every o	other						
FORM CMS-2	567(02-99) Previous Versi	ions Obsolete	Event ID:	RJDD11	Facility I	D: 000092	If continuation sh	eet Pa	ge 36 of 49

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155176		LDING	NSTRUCTION 00	(X3) DATE COMPL 12/02/2	ETED	
	PROVIDER OR SUPPLIER	I FION & SKILLED NURSING CENT	3811 PA	DDRESS, CITY, STATE, ZIP CODE ARNELL AVE VAYNE, IN46805	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	alert sheet. The weight loss, wo indicated she he was ince she shack in July. The Certified Downs interviewed p.m., along with interview, the County was and that shad refused past and that shad refused past and that shad refused the weight interview interview.	the residents on the ose residents with bunds, etc. She further ad not seen Resident started her RD position ietary Manager (CDM) don 12/2/11 at 1:47 in the RD. During the CDM indicated Resident d supplements in the he had tried other such as peanut butter.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155176		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/02/2	ETED	
	ROVIDER OR SUPPLIER	FION & SKILLED NURSING CENT	ER	3811 PA	DDRESS, CITY, STATE, ZIP CODE ARNELL AVE VAYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI TAG DEFICIENCY)		ΓE	(X5) COMPLETION DATE
F0329 SS=D	from unnecessary drug is any drug we (including duplicate duration; or without without adequate in the presence of accordinate the dose of discontinued; or an reasons above. Based on a comproper resident, the facility residents who have drugs are not give antipsychotic drug treat a specific cordocumented in the residents who use gradual dose reduinterventions, unlein an effort to disconsect the facility failed were ordered to effectiveness or for 1 of 10 residents who met the crimedication in the state of the facility failed were ordered to effectiveness or for 1 of 10 residents who met the crimedication in the state of the facility failed were ordered to effectiveness or for 1 of 10 residents who met the crimedication in the state of the facility failed who met the crimedication in the state of the facility failed who met the crimedication in the state of the facility failed who met the crimedication in the state of the facility failed who met the crimedication in the state of the facility failed who met the crimedication in the state of the facility failed who met the crimedication in the state of the facility failed who met the crimedication in the state of the facility failed who met the crimedication in the state of the facility failed who met the crimedication in the state of the failed who met the crimedication in the state of the failed who met the crimedication in the state of the failed who met the crimedication in the state of the failed who met the crimedication in the state of the failed who met the crimedication in the state of the failed who met the crimedication in the state of the failed who met the crimedication in the state of the failed who met the crimedication in the state of the failed who met the crimedication in the state of the failed who met the crimedication in the state of the failed who met the crimedication in the state of the failed who met the crimedication in the state of the failed who met the crimedication in the state of the failed who met the crimedication in the state of	f medication therapy dents (Resident #54) teria for unnecessary ne stage 2 sample of e: Resident #54 was /30/11 at 3:00 P.M. uded, but were not rlipidemia (high levels	F0	329	F 329: Drug Regimen is Free From Unnecessary Drugs:It i practice of this facility to provresidents with a drug regimer is free from unnecessary dru. What corrective action(s) will accomplished for those resid found to have been affected the deficient practice? Reside #54 admitted to facility on 07/05/11 with orders for prescribed medications and necessary lab work. Labs we drawn on 12/01/11 and revier by the Physician with no new orders. How will you identify other residents having the potential to be affected by the same deficient practice and vecorrective action will be taken	s the ride n that gs. be ents by ent with ere wed r	12/29/2011

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155176	A. BUI	LDING	00	COMPL 12/02/2	
		155176	B. WIN			12/02/2	011
NAME OF I	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE		
01 51100	001/ 0511/001174	TION A OLULI ED MUDOINO OEM			ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CENT	IEK	FORTV	VAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	A physician's or Resident #54 for indicated the reclipitor (medicated levels) 40 milling Tricor (medicated levels) 145 milling The record individual been prescribed since July 2017. A drug reference "Nursing 2011 which was furn (Director of Nursing 2011 which was furn (Director of Nursined prior to then periodical Lipitor and Tricon There was no in #54's record of obtained to assist since the Lipid initiated. The consulting physician order July 2011, Aug 2011, October 1900 milling 1900 millin	order monthly recap for or December 2011, esident was prescribed tion used to lower lipid grams at bedtime and tion used to lower lipid igrams at bedtime. It is is to the resident had the determinent of these medications 1. The book, entitled Drug Handbook", ished by the DoN resing) on 12/2/11 at cated lab testing for lipid levels should be to starting therapy and ly thereafter for both		TAG	Residents receiving Antiliper have the potential to be affect by the alleged deficient pract DNS and/or designee to review residents receiving Antiliper for need of additional lipid partial lab work. What measures with put into place or what system changes will you make to ensure that the deficient practice do not recur? DNS and/or designee to review all new admission a re-admissions, within 72 hour medications for necessary lawork if prescribed an Antiliper This is to be completed during morning meetings and information will be forwarded the pharmacy consultant for review. DNS will review Antilipemic with pharmacy consultant on the next visit. The corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., with quality assurance program with put into place? DNS and/or designee to use the Lab Diagnostic CQI form weekly weeks, monthly for 3 months then quarterly for 6 months a results forwarded to CQI committee monthly for review DNS and/or designee will util the Supplement CQI and the Care Plan CQI weekly for 4 weeks, monthly for 3 months then quarterly for 6 months. Findings will be forwarded to CQI committee monthly for 1 months. Findings will be forwarded to CQI committee monthly for 1 months. Findings will be forwarded to CQI committee monthly for 1 months.	eted ice. ew all ics nel ill be nic sure es and rs, b mic. g to How e cient nat rill be for 4 , nd v. ize , and	DATE
		nd been reviewed.			review. The CQI committee	will	
	There were no	recommendations in			develop an action plan if		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155176	B. WIN	G		12/02/2	011
	ROVIDER OR SUPPLIER	TION & SKILLED NURSING CENT	ER	3811 PA	DDRESS, CITY, STATE, ZIP CODE ARNELL AVE VAYNE, IN46805		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDENCE N. AM OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	, L	DATE
		dicate the pharmacist monitoring lipid levels.			threshold of 90% is not met.		
	The facility DoN was interviewed on 12/1/11 at 3:40 P.M. During the interview, the DoN indicated no lab tests for lipid levels had been obtained for Resident #54. The DoN indicated the consulting pharmacist had reviewed Resident #54's medications, but had made no recommendations regarding monitoring lipid levels. The DoN further indicated the facility's current pharmacy did not make as many recommendations for lab tests in the medication reviews as the previous pharmacy had done. 3.1-48(a)(3)						
F0333 SS=D	free of any signific Based on observe interview the fac insulin was given for 2 of 16 reside	ensure that residents are cant medication errors. ation, record review and cility failed to ensure at the appropriate time ents (#25 & #3) observed on administration in the f 35.	F0	333	F 333: Residents Free From Significant Med ErrorsIt is the practice of this facility to ensithat residents are free of any significant medication errors. What corrective action(s) will accomplished for those resid found to have been affected	ure be ents	12/29/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED COMPLETED					
AND PLAN	OF CORRECTION	155176	A. BUI	LDING		12/02/20	
		100170	B. WIN			12/02/20	311
NAME OF I	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP CODE		
CI ENDD	OOK DEHVBII ITV.	TION & SKILLED NURSING CEN	ITED		ARNELL AVE NAYNE, IN46805		
			IIEK				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	·	14/00	DATE
					the deficient practice? There no negative outcome from the		
	Finding Includes:			no negative outcome fror alleged deficient practice			
					Resident #25 and Resident	# 3.	
	1. Observation of	of medication pass on			Individual education for Nurs	e	
	12/1/11 at 3:20 p	o.m. indicated resident			#19 will occur by 12/29/11.		
	#25 had a blood	sugar of 179. Review of			will you identify other resider		
	the residents med	dication administration			having the potential to be aff by the same deficient praction		
	orders indicated	the resident was to			and what corrective action w		
	receive 2 units o	f Novolin-R insulin.			taken? All residents receivir		
	Nurse #19 drew up the insulin and				short acting insulin have the		
	administered it to	•			potential to be affected by al	~	
	Observation of medication pass on				deficient practice. An audit of resident medication	of all	
					administration records will be	_	
		-			done to identify residents wh		
	_	o.m. indicated resident #3			receive short acting insulin.		
		r of 415. Nurse #19			Physician will be notified of t		
		ician related to the high			administration guidelines and		
		was told there was no			orders will be obtained in orders be in compliance with the sh		
		ervation of nurse #19			acting insulin guidelines. Wi		
		ew up 12 Units of			measures will be put into pla		
	Humalog 100 In	sulin as was ordered and			what systemic changes will y		
	administered the	insulin to the resident.			make to ensure that the defi	cient	
					practice does not recur?	4:	
	On 12/1/11 at 3::	30 p.m. interview with			Residents receiving short ac insulin have been reviewed a	-	
	nurse #8 indicate	ed the residents do not			changes have been made to		
	receive their eve	ning meal until 5:45 p.m.			sliding scale to ensure timeli		
					of administration of insulin.	DNS	
	On 12/2/11 at 9:	15 a.m. the Director of			and/or designee will review		
		I the insulin information			physician orders during more meeting to ensure physician	ning	
					orders follow guidelines. A s	skills	
	sheets. Review of the medication information sheets indicated the insulin			check off list will be complete			
					Unit Manager and/or designe	ee on	
	should be given within 15 minutes of starting a meal to 20 minutes after starting			all nurses to ensure they are			
	_	-			following the insulin protocol		
	a meal depending	g on regimen.			How the corrective action(s) be monitored to ensure the	WIII	
					De monitored to ensure the		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155176		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/02/2	ETED	
		155170	B. WIN	G		12/02/2	011
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CENT	ER	3811 PA	ADDRESS, CITY, STATE, ZIP CODE ARNELL AVE VAYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	"Mosby's 2012 N indicated Novoli acting insulin wi minutes and Hur	Nursing Drug Reference" n-R insulin is a short th an onset of action at 30 malog insulin is a rapid th an onset of 15 to 30			deficient practice will not recipies., what quality assurance program will be put into place DNS and/or designee to use MAR/TAR CQI form weekly for tweeks, monthly for 3 months then quarterly for 6 months thereafter. Results will be forwarded to the CQI commit monthly for review. If thresh 90% is not met, then CQI committee will develop an additional action plan. DNS and/or designee, using the ID admission/readmission reviet tool, will review all new admissions and re admission ensure residents who receive short acting insulin will have orders that reflect protocol. A blood glucose-monitoring too been implemented showing the actual time the short acting Insulin is administrated per Physician's orders and manufacturer's guidelines. Tool will be used daily for the next 1 month, then monthly fronths. If the threshold of 9 is not met; the CQI committe implement an action plan. Non-compliance may result in disciplinary action up to and including termination.	e? the for 4 tee old of This he fhis or 6 0% e will	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155176		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/02/2	ETED	
	ROVIDER OR SUPPLIER	TION & SKILLED NURSING CENT	ER	3811 PA	ADDRESS, CITY, STATE, ZIP CODE ARNELL AVE VAYNE, IN46805		
	SUMMARY S' (EACH DEFICIEN REGULATORY OR The nursing facility from an outside re §483.75(h) of this covered under the emergency dental of each resident; r the resident in ma arranging for transdentist's office; an residents with lost dentist. Based on obse and interview the assess and profor 1 of 3 resident criteria for dentification. Finding include Observation of 11/28/11 at 2:0 resident had brown teeth on the up of her mouth. On 11/30/11 at the resident had brown the resident had brown the up of her mouth.	TION & SKILLED NURSING CENT TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) y must provide or obtain source, in accordance with part, routine (to the extent e State plan); and services to meet the needs must, if necessary, assist king appointments; and by sportation to and from the d must promptly refer or damaged dentures to a rvation, record review ne facility failed to evide dental services ents (#55) who met the hal status and services. es: resident #55 on 0 p.m. indicated the eoken and decayed per and lower portion 10:15 a.m. review of edmission nursing ted 4/5/10, indicated d reddened gums.				Dental ctice otain utine ses to dent. be ents by lent ain no 55 to darch y e what o be	(X5) COMPLETION DATE 12/29/2011
	the dental section. On 12/2/11 at 10:30 a.m. Interview with the director of nursing indicated				Director and/or designee will review all residents' most cur dental assessment for any de needs and follow up accordir What measures will be put in	rrent ental ngly.	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155176		ĺ	LDING	NSTRUCTION 00	(X3) DATE S COMPLI 12/02/20	ETED	
	PROVIDER OR SUPPLIER	L FION & SKILLED NURSING CE		STREET AT	DDRESS, CITY, STATE, ZIP CODE IRNELL AVE /AYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	regarding resid a dentist. The the initial assess teeth which ind On 12/2/11 at 1 with the Social indicated the reseen by a dentihave any documesident being a	re any information ent #55 being seen by only information was sement of the resident's icated reddened gums. 10:33 a.m. interview Service Director esident had not been ist and she did not mentation of the asked on admission if inted to be seen by the			place or what systemic change will you make to ensure that deficient practice does not resolved interdisciplinary Team will resoral assessments during resident's care plan review. Nurses are responsible to complete oral assessments of residents and Social Services follow up on any needs. How corrective action(s) will be monitored to ensure the defic practice will not recur, i.e., where the defic practice will not recur, i.e., where the program we put into place? Social Services Director and/or designee to perform the Dental Services of the dental services weekly for weeks, monthly for 3 months then quarterly for 6 months a forward findings for CQI committee monthly for review The CQI committee will developed an additional action plan for a findings not meeting the three of 90%.	the cur? view on all s will the cient nat rill be es cQI r 4 r, nd v. lop any	
F0428 SS=D		of each resident must be once a month by a licensed					
	to the attending ph nursing, and these upon.	ust report any irregularities hysician, and the director of e reports must be acted	FO)428	F 428: Drug Regimen Review Report Irregular and Act On:		12/29/2011
EODM CMC		rd review and interview,	D IDS ::	p 111. **	the practice of this facility to	have	44 545
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AND PLAN OF CORRECTION IDENTIFICA		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE COMPL	
		155176	B. WIN			12/02/2	011
NAME OF A				STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF	PROVIDER OR SUPPLIER	C		3811 P	ARNELL AVE		
		TION & SKILLED NURSING CEN	TER	FORT V	VAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	,		DATE
	1	nsulting pharmacy had			a Licensed Pharmacist revie each resident's drug regimer		
	failed to recommend lab tests were ordered to assess for the effectiveness of medication therapy				What corrective action(s) will		
					accomplished for those resid		
					found to have been affected		
	for 1 of 10 resid	dents (Resident #54)			the deficient practice? Resid	dent	
	reviewed for ur	nnecessary			#54 admitted to facility		
		a stage 2 sample of			on07/05/11 with orders for	***	
	35.				prescribed medications and		
					necessary lab work. Labs w drawn on 12/01/11 and revie		
	Findings includ	e.			by the Physician with no new		
	The record for Resident #54 was reviewed on 11/30/11 at 3:00 P.M.				orders. How will you identify		
					other residents having the		
					potential to be affected by th	е	
					same deficient practice and		
		uded, but were not			corrective action will be take		
		erlipidemia (high levels			Residents receiving Antiliper		
	of lipids, or fat,	in the blood).			have the potential to be affect by the alleged deficient practi		
					DNS and/or designee to revi		
	A physician's o	rder monthly recap for			residents receiving Antilipem		
	Resident #54 fo	or December 2011,			for need of additional lipid pa	nel	
	indicated the re	esident was prescribed			lab work. What measures w		
	Lipitor (medica	tion used to lower lipid			put into place or what systen		
	, ,	grams at bedtime and			changes will you make to en		
		tion used to lower lipid			that the deficient practice do not recur? DNS and/or design		
	,	igrams at bedtime.			to review all new admission	•	
	1 '	cated the resident had			re-admissions, within 72 hou		
		d these medications			medications for necessary la		
	since July 201				work if prescribed an Antilipe		
	Silice July 201	1.			DNS will review Antilipemic v		
	Λ drug == f= == ==	an book antitled			pharmacy consultant on nex		
	_	ce book, entitled			visit. How the corrective acti will be monitored to ensure t		
	1	Drug Handbook",			deficient practice will not rec		
		ished by the DoN			i.e., what quality assurance	 ,	
	(Director of Nursing) on 12/2/11 at				program will be put into place	e?	
	8:00 A.M., indic	cated lab testing for			DNS and/or designee to use		
	baseline blood	lipid levels should be			Lab Diagnotic CQI form wee		
	obtained prior t	o starting therapy and			for 4 weeks, monthly for 3		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(2	X2) MU	LTIPLE CO	NSTRUCTION		(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A	. BUIL	DING	00		COMPL	
		155176	В	B. WINC	} <u> </u>			12/02/2	U11
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
						RNELL AVE			
GLENBR	OOK REHABILITA	TION & SKILLED NURSING	CENTE	R	FORT W	/AYNE, IN46805			
(X4) ID		TATEMENT OF DEFICIENCIES			ID		N OF CORRECTION		(X5)
PREFIX	, The state of the	ICY MUST BE PERCEDED BY FULL		I	PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED 1	CTION SHOULD BE TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	1)		TAG	DEFICIE	-		DATE
		ly thereafter for both				months, then que months and for	,		
	Lipitor and Tricor.					CQI committee		to trie	
	There was no i	ndication in Resident				review. The CO	QI committee		
#54's record of la obtained to asses						for any findings			
		0 0				threshold of 909		-	
		and Tricor had been							
	initiated.								
The consulting pharmacist signed the									
physician order monthly recaps for									
	July 2011, August 2011, September								
	2011, October 2011, and November								
	2011 indicating	Resident #54's							
	medications ha	nd been reviewed.							
	There were no	recommendations in							
		dicate the pharmacist							
		monitoring lipid levels.							
	The facility Do	N was interviewed on							
		P.M. During the							
		DoN indicated no lab							
	tests for lipid le								
		esident #54. The DoN							
		onsulting pharmacist							
	had reviewed F	• .							
		ut had made no							
	recommendation								
		l levels. The DoN							
		d the facility's current							
		not make as many							
	l · •	•							
	recommendations for lab tests in the medication reviews as the previous								
	pharmacy had	•							
	priarriacy riau	dono.							
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155176	A. BUII B. WIN			12/02/2	011
			D. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CENT	ER		VAYNE, IN46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The facility must meach resident in approfessional stand complete; accurate accessible; and sy. The clinical record information to identhe resident's asseand services provipreadmission scresstate; and progress Based on record the facility failed documentation Dietitian (RD)/C Manager (CDM resident (#40) i 35. Findings include Laboratory repaindicated Residumin. The Nutrition R 4/5/11, indicate albumin and ottivalues were with the sident in the sident of the sident in the	naintain clinical records on accordance with accepted lards and practices that are ely documented; readily estematically organized. I must contain sufficient a record of essments; the plan of care ided; the results of any ening conducted by the se notes. I'd review and interview, do to ensure by the Registered Certified Dietary (1) was accurate for 1 and a stage 2 sample of es. Ort, dated 2/10/11, dent #40 had a low present the plan of care ided; the results of any ening conducted by the ses notes.	F0		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	le:It o each ards ete; lilly ly d for e t ary 11.	
	,	s Progress Notes, ndicated Resident #40			residents having the potentia be affected by the same defice		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155176			LDING	ONSTRUCTION 00	(X3) DATE COMPL 12/02/2	ETED	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			ARNELL AVE		
		TION & SKILLED NURSING CEN	ΓER		WAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)	+	TAG	,		DATE
		s of malnutrition with			practice and what corrective action will be taken? Reside		
		n recorded as 13.3			who has pressure sores,		
	(18-35.7).				significant weight changes, a	are on	
					enteral feedings, and/or have		
		Risk Assessment, dated			abnormal labs affecting nutri		
	5/27/11, indicated lab values for albumin and other nutrition related lab				status has the potential to be		
					affected by the alleged defici practice. Dietary Manager a		
	values were wi	thin normal limits.			Registered Dietitian will audi		
					dietary care plans on resider		
	Laboratory report, dated 6/16/11, indicated Resident #40 had a low albumin, total protein and albumin levels.				who have pressure sores,		
					significant weight changes, h		
					enteral feedings, or abnorma		
					labs affecting nutritional state any updated needed. What	JS 101	
					measures will be put into pla	ce or	
	The Nutrition R	Risk Assessment, dated			what systemic changes will y		
		ted lab values for			make to ensure that the defic		
	· ·	her nutrition related lab			practice does not recur? Die	-	
		thin normal limits.			Manager educated on progre note documentation and diet		
					care plans on 12/15/11. DN	-	
	An interview w	as conducted with the			and/or designee will update		
		sing and Health Facility			Registered Dietitian alert she	eets	
		on 12/2/11 at 9:00 a.m.			for residents of nutritional		
		rview, the Director of			concern, wounds, weight		
	_	ed the notes prior to			changes, and abnormal labs relating to nutritional status of		
	_	previous dietitian.			weekly basis. Registered	,,,	
	i daiy were ure p	novious dictitian.			Dietitian to review a random		
	3.1-50(a)(1)				sample of dietary care plans		
	3.1-50(a)(2)				monthly and forward findings		
					the CQI committee monthly f review. How the corrective	or	
					action(s) will be monitored to)	
					ensure the deficient practice		
					not recur, i.e., what quality		
					assurance program will be p		
					into place? DNS and/or des		
					will utilize the Supplement C		
			1		and the Care Plan CQI week	ay tor	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		155176	A. BUII B. WIN			12/02/2	011	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
GLENBROOK REHABILITATION & SKILLED NURSING CEN			3811 PARNELL AVE TER FORT WAYNE, IN46805					
				<u> </u>	VATINE, IN400UD		OUT.	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
					4 weeks, monthly for 3 month then quarterly for 6 months thereafter. Findings will be forwarded to the CQI commitmonthly for review. The CQI committee for any findings meeting the threshold of 90% develop an action plan. Registered Dietitian to review random sample of dietary are plans monthly and forward findings to the CQI committee monthly for review. Dietary Manger and/or designee will the Dietary Recommendation tool weekly for 4 weeks, mor for 3 months, then quarterly months. Findings will be forwarded to the CQI commitmonthly for review. The CQI committee for any findings meeting the threshold of 90% develop an action plan.	ns, ttee ot 6 will v a e use n CQI othly for 6		